INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION DEFICIENCIES REPORT

Name of Facility

DEFICIENCIES		COMMENTO
1. DATA TAG NO.	2. COP/STND NO.	COMMENTS

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FOR INITIAL OR ANNUAL RECEI I certify that I have reviewed the follow (c) Fundamental Survey, and unle Condition of Participation.	RTIFICATION SURVEY ring requirements and condition for: (a) Full Survey ess indicated on this form, the facility was found to be	, (b) Extended Survey, or in compliance with the Standard and the
SIGNATURE	TITLE	DATE
SIGNATURE	TITLE	DATE
compliance during the survey onStandard and/or the Condition of Partic		cility was found to be in compliance with the
SIGNATURE	TITLE	DATE

INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION DEFICIENCIES REPORT-INSTRUCTIONS

Evaluate each of the requirements identified in the ICF/MR Interpretive Guidelines, (Appendix "J" to the SOM). For each identified deficiency:

- A. In the first column, identify the data tag number.
- B. In the second column, write the regulatory citation. If it is a Condition of Participation, enter "CoP" below the regulatory citation.
- C. In column three, describe deficient facility practice and supporting findings.
- D. Draw horizontal lines to separate identified tag numbers.
- E. If more space is needed, photocopy FIRST page (front and back).
- F. Each surveyor must sign the certifying statement on the last page.
- G. If there are more surveyors to sign the last page, than are lines available on which to sign, photocopy the last page, and add the additional signatures.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 9938-0062. The time required to complete this information collection is estimated to average 3 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.